

Smokefree initiatives

- Prior to 2008, most hospitals had 'smoking rooms'.
- From 1 July 2008, all these were closed. Most hospitals still permitted smoking outside in the grounds.
- But some did not:
Nottingham NHS Trust introduced a policy in April 2007 that prohibited smoking in the grounds of all the Trust buildings, including Rampton Hospital, save in exceptional circumstances, on risk management and health and safety grounds.

*R (N) v SSH; R (E) v Nottinghamshire Healthcare
NHS Trust [2009] EWCA Civ 795*

- A number of Rampton patients judicially reviewed both the Trust and the Secretary of State for Health in the High Court to argue that they had a fundamental human right to smoke - as part of the right to respect for private and family life enshrined in Article 8 of the European Convention on Human Rights (ECHR).
- They also argued that, because smoking is still permitted in prison, they were being discriminated against because of their mental health problems contrary to Article 14 ECHR (prohibition of discrimination).

- The freedom protected by art 8 was not the same as the freedom to do whatever a person chose to do.
- The issue as to the scope of art 8 should be answered by considering whether smoking was an activity integral to a person's identity, or was an aspect of social interaction, or whether the hospital was to be regarded as a patient's home within the meaning of art 8.
- The hospital was the claimants' home, but it was not the same as a private home and the distinction was of significance. It was a public institution. Supervision was intense for safety and security reasons. It was in that context that the nature of the activity had to be considered. What was important was freedom from interference by the state. That freedom was already significantly restricted within the confines of a secure hospital.
- There was no basis for distinguishing the loss of freedom to choose what to eat or drink in such an institution and the ban on smoking. Art 8 applied to closed institutions, but to a far more limited extent than it would to activities in a person's home.

- The less the claimant could rely upon the nature of the place in which the activity was pursued, the more he had to rely upon the proximity of the activity to his personal identity or physical and moral integrity.
- Difficult as it was to judge the importance of smoking to the integrity of a person's identity, it was not sufficiently close to qualify as an activity meriting the protection of art 8.
- Art 8 did not protect a right to smoke at the hospital. The prohibition did not, in such an institution, have a sufficiently adverse effect on a patient's physical or mental integrity. The appeals under art 8 failed. If art 8(1) standing alone was not engaged, the right to smoke could not come within the ambit or scope of art 8 for the purposes of art 14.
- If art 8 had been engaged, the trust and the Secretary of State had successfully justified the ban within art 8(2).

Lord Justice Keene – a dissenting voice

“I quite accept the point made by the majority that, if Article 8 is engaged by a ban on smoking in the home or the institutional equivalent to the home, it could also be engaged if government were to prohibit the playing of chess or bridge or listening to music, and so on. But I do not regard that as an obstacle to regarding Article 8 as being engaged – indeed, quite the opposite.

One would hope that, were the executive to seek to interfere with such activities when conducted in private, it would be required to justify the interference under Article 8(2)”

Blanket restrictions

1

the term 'blanket restrictions' refers to rules or policies that restrict a patient's liberty and other rights, which are routinely applied to all patients, or to classes of patients, or within a service, without individual risk assessments to justify their application.

(Mental Health Act *Code of Practice*, para 8.5)

Blanket restrictions

2

Blanket restrictions include restrictions concerning:

- access to the outside world,
- access to the internet, [email or social media]
- access to (or banning) mobile phones and chargers,
- incoming or outgoing mail,
- visiting hours,
- access to money or the ability to make personal purchases, or
- taking part in preferred activities.

Such practices have no basis in national guidance or best practice; they promote neither independence nor recovery, and may breach a patient's human rights

(Mental Health Act *Code of Practice*, para 8.7)

Blanket restrictions

3

Restrictions that apply to all patients in a particular setting (blanket or global restrictions) should be avoided. There may be settings where there will be restrictions on all patients that are necessary for their safety or for that of others. Any such restrictions should have a clear justification for the particular hospital, group or ward to which they apply.

(Mental Health Act *Code of Practice*, para 1.6)

A man with glasses and a white t-shirt is shouting with his mouth wide open in a restaurant setting. He is pointing towards another man in a white shirt. The background shows a dining area with tables and chairs.

I want my cigarettes!

Mental health care providers have a duty of care to protect the health of, and promote healthy behaviour among, people who use, or work in, their services. This includes providing effective support to stop smoking or to temporarily abstain from smoking while using or working in secondary care inpatient services . Services are increasingly mandated by their commissioning authorities to implement comprehensive smokefree policies, where smoking is banned within the whole hospital estate and tobacco dependence treatment pathways are integral to service provision. Smokefree policies might be perceived as contentious, particularly in services where there is a lack of support to effectively manage nicotine withdrawal and provide a range of alternative activities. However, in response to legal challenges, the Court of Appeal has ruled that smokefree policies do not infringe human rights.

CQC inspections should not challenge smokefree policies, including bans on tobacco smoking in mental health inpatient services (for example, by raising such policies as a unwarranted 'blanket restriction'). Instead, focus should be paid on whether such a ban is mitigated by adequate advice and support for smokers to stop or temporarily abstain from smoking with the assistance of behavioural support, and a range of stop smoking medicines and/or e-cigarettes. Inspections should also consider whether alternative activities are in place and promoted, including regular access to outside areas.

Reporting

- The fact that a service is smokefree should not itself be raised as a concern about 'blanket restrictions'. Blanket bans on e-cigarettes that have no cogent justification could, however, be raised as blanket restrictions.
- Where services have implemented smokefree policies without tobacco dependence training for staff, access to smoking cessation support (i.e. nicotine replacement therapy (NRT), varenicline and/or e-cigarettes), this should be discussed under the 'effective' section of the report.
- Appropriate medication reviews and monitoring should be completed to ensure that medicines doses are altered when necessary, as smoking status changes. This should be discussed under the 'safe' section of the report.

	POLICY
1	Was the smokefree policy, developed in collaboration with staff and people who use secondary care services, or their representatives?
2	Are all staff aware of the smokefree policy and do they comply with it?
3	Are all staff provided with information about the smokefree policy and instructions about their roles and responsibilities in maintaining a smokefree work environment?
4	Does the organisation provide everyone with verbal and written information and advice about the smokefree policy before their appointment, procedure or hospital stay?

	TRAINING
5	Is there a requirement that all staff are trained to deliver advice on stopping smoking and to make a referral to intensive support?
6	Are all frontline staff trained to deliver advice around stopping smoking and referral to intensive support? They should know what local and hospital-based stop smoking services offer and how to refer people to them.
7	Are all frontline staff trained to talk to people in a sensitive manner about the risks of smoking and benefits of stopping?
8	Are all staff who deliver intensive stop smoking support trained to the minimum standard described by the NCSCT, with additional training that is relevant to their clinical specialism?

	SUPPORTING SERVICE USERS
9	During the first face-to-face contact, do staff ask everyone if they smoke or have recently stopped smoking and record smoking status and the date they stopped, if applicable, in the person's records (preferably computer-based) and any hand-held notes?
10	Before a planned or likely admission, do staff work with the person to include the management of smoking on admission or entry to the secondary care setting in their personal care plan?
11	Does the trust encourage everyone who smokes to stop smoking completely and if necessary provide immediate access to NRT or other pharmacotherapies when appropriate?
12	Do staff offer and, if the person agrees, arrange for them to receive intensive behavioural support, either during their current outpatient visit or during their inpatient stay?
13	Do staff encourage the use of NRT for anyone who does not want, is not ready or is unable to stop completely?

14	<p data-bbox="144 97 1626 292">Do staff ensure that people who use drugs that are affected by smoking (or stopping smoking) are monitored, and the dosage adjusted if appropriate?</p> <ul data-bbox="144 339 1819 935" style="list-style-type: none"><li data-bbox="144 339 1819 721">• Stopping smoking can reduce metabolism of several psychotropic medicines resulting in higher, sometimes toxic blood levels over a few days. This applies in particular to clozapine and olanzapine, two commonly used antipsychotic medications. Clinical guidelines recommend reducing doses of these drugs and monitoring blood levels before and at weekly intervals after stopping smoking until levels have stabilised.<li data-bbox="144 763 1819 935">• Services should be mindful of potential consequences to medication plasma-levels should patients resume smoking upon discharge, or smoke heavily when given off-site leave.
15	<p data-bbox="144 958 1787 1153">When people are discharged from hospital, do staff ensure they have sufficient stop smoking pharmacotherapy to last at least 1 week or until their next contact with a stop smoking service?</p>

	SUPPORTING STAFF
16	Does the service advise all staff who smoke to stop? Offer staff in-house stop smoking support? Provide contact details for community support if preferred? Allow staff to attend stop smoking services during working hours without loss of pay?
17	Does the service support staff who do not want, or are not ready or able to stop completely to use licensed nicotine-containing products to help them abstain during working hours?
18	Does the service offer and provide intensive behavioural support to maintain abstinence from smoking during working hours?

	ENVIRONMENT
19	Are all stop smoking pharmacotherapies included in secondary care formularies?
20	Does the hospital pharmacy stock varenicline, bupropion and a full range of NRT (including transdermal patches and a range of fast-acting products) for patients and staff?
21	Do all hospitals have an on-site stop smoking service?
22	Is a range of NRT available for sale in hospital to visitors and staff?

23

Is use of e-cigarettes included as a component of a strategy to help people quit or cut down? If not, why not, and does the policy reflect NCSCT guidance on e-cigarettes

(<http://www.ncsct.co.uk/usr/pdf/Electronic%20cigarettes.%20A%20briefing%20for%20stop%20smoking%20services.pdf>)?

- E-cigarettes should not routinely be treated in the same way as smoking. It is not appropriate to prohibit e-cigarette use in health services as part of smokefree policies (see policy position in above brief guide).
- Some e-cigarette devices contain heating elements and batteries that may pose risks on mental health wards, CQC will expect services to explore individual risk assessment and the use of alternative models of e-cigarette to mitigate these, rather than a blanket ban on the use of e-cigarettes. There is, for example, an e-cigarette model approved for use in prisons.
- There is increasing flexibility in the ways in which some services are responding to e-cigarette technologies as a way of managing smokefree services. For example, some mental health services have allowed that patients may use electronic cigarettes in certain indoor spaces (such as patients' own bedrooms).

	SYSTEMS
24	Are discussions and decisions related to stop smoking advice, referrals or interventions recorded in the person's records (preferably computer-based)?
25	Are systems in place to alert the person's healthcare providers and prescribers to changes in smoking behaviour because other drug doses may need adjusting?
26	Is a robust system in place (preferably electronic) to ensure continuity of care between secondary care and local stop smoking services for people moving in and out of secondary care?

RISKS AND MITIGATION OF RISKS

- 27 What risks have been identified in relation to the smokefree policy, and how have these been mitigated?
- Especially in acute services, are patients informed of the policy before admission, and do staff consider whether this is having any effect on patients' willingness to be admitted?
 - For all services, are the rules associated with the smokefree status fully explained to patients, including the ward policy in relation to the retention (or destruction) of smoking materials that patients might have on them on admission, or on return from leave (see 28 below).

- Check whether the smokefree policy (or any safety issue arising from surreptitious smoking) is being enforced by searches, and if so how the service is ensuring proportionality in such security measures. In general terms, searching people on a health promotion premise is unlikely to be appropriate, but searching may be a proportionate response to risks associated with cigarette lighters etc.
- Likely problems in the implementation of the smokefree policy include fire-risks through surreptitious smoking, or the risk of exploitation of vulnerable patients as a result of illicit markets in smoking materials.
- Services should have identified any patient at risk of exploitation and sought to counter this.

Services that provide access to NRT or e-cigarettes may be less likely to experience illicit markets in smoking materials.

28	<p>How do services manage patients who return from leave with cigarettes in their possession? The smokefree policy should clearly state how staff should respond when patients bring smoking materials into a smokefree environment. These arrangements should be clearly communicated to people who use services. Services are likely to require patients to hand over any smoking materials. Some services will return these when that patient is next leaving the hospital site. Others only return confiscated smoking materials upon eventual discharge, which could be challenged under the MHA Code of Practice principle of least restriction. Other services have reported destroying any confiscated smoking products, which may also raise questions of legal authority to do so.</p>
29	<p>In acute services, do staff report any changes in admission patterns that may be linked to the smoking ban – for example, do patients refuse informal admission?</p>